

CLAIM FORM

In this form, Scottish Widows plc has been referred to as "the Company".

Please note that the issue of this Form is not an admission of liability

1a) **Policy Number:** _____

1b) **Life Assured:** _____

1c) **Date of Death:** _____

2a) **Full name of Claimant(s) (Block Letters):** _____

2b) **Present Address :** _____

Telephone Number: _____

2c) **Capacity of Claimant:** _____
(e.g Trustee, Executor, Policyholder, Assignee, etc)

3 Payment Details

3a) **Details of Payee (for proceeds of cheque):** _____

3b) **Address where payment should be sent:** _____

3c) **Please enter any reference:** _____

3d) **Details of Bank account to be credited:**
Please credit my/our bank/building society account below:

Bank/Building Society: _____

Sort Code (6 Numbers): _____

Account Number: _____

Account held in the name(s) of: _____

Building Society Reference (if applicable): _____

Please note that when a cheque or direct credit payment reaches your bank/building society, it will take a minimum of 3 days to clear and allow you access to the money.

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Declaration

I/We hereby claim the life assurance benefit and I/We certify that the statements over are true and complete.

I/We authorise and request the Company to make payment of the by claim crossed cheque in favour of the Payee and that the crossed cheque is sent by post at my/our risk to the address stated.

I/We consent to the Company seeking medical information from any doctor who at any time has attended the Life Assured concerning anything which affected his/her physical or mental health.

I/We agree that any payment made by the Company shall be in full and final settlement of any claims which I/We the undersigned can or may have under the policy/ies and I/We agree to indemnify the Company against all losses, claims, costs and demands to which the company may be put in consequence of such payment.

**PLEASE INDICATE IF THE FOLLOWING ARE APPLICABLE
(Indicate by ticking the relevant box)**

4a) The Original Policy Document cannot be found

Indemnity and Declaration for missing policy documents (applicable if the above box is ticked)

I/We declare that the original policy documents, for the above numbered policy has been lost, mislaid or destroyed and although searches have been made, it had not been traced.

To the best of my/our knowledge it has not been assigned, mortgaged, settled, deposited, charged or otherwise dealt with in a way which affects its title. (Other than already advised). I further declare that I am / we are legally entitled to the policy and will forward it to the Company for cancellation should it be found.

I/We request that payment be made under the above policy and in consideration of the Company agreeing to pay the full amount of the policy proceeds notwithstanding the loss of the policy, I/We hereby agree to indemnify the Company against all losses, claims, costs and demands to which the Company may be put in consequence of such payment.

4b) It is not intended to apply for a Grant of Representation

In consideration of the payment made by the Company to me/us under the above policy without production of a Grant of Representation, I/We hereby agree to indemnify the Company against all losses, claims, costs and demands to which the Company may be put in consequence of such payment.

4c) Did the Deceased leave a valid Will?

 Y/N

(If Yes, please forward a Certified Copy of the original)

(The next-of-kin should sign below where there is not a Will: the Executors where a valid Will exists. Please note the Company reserves the right to insist on sight of a Grant of Representation if it is deemed necessary).

Signed: _____
(First Claimant)

Date: _____

Signed: _____
(Second Claimant – if applicable)

Date: _____

Signed: _____
(Third Claimant – if applicable)

Date: _____